

Ethics, legal, social and counselling

Should requests for donor insemination on social grounds be expanded to transsexuals?



Patricia Baetens obtained her MA degree in the Faculty of Psychology and Educational sciences at the Dutch-speaking Brussels Free University in 1989. She continued working as a researcher at the same faculty from 1991 to 1999, while at the same time working part-time as a psychologist at the university's Centre of Reproductive Medicine before taking up a full-time position in 1999. She is predominantly involved in counselling in third party conception. She has published and presented papers both on counselling couples for oocyte donation and on counselling homosexual couples and single women for donor insemination.

Dr Patricia Baetens

P Baetens¹, M Camus, P Devroey

Centre for Reproductive Medicine, University Hospital, Dutch-speaking Brussels Free University, Laarbeeklaan 101, B-1090 Brussels

¹Correspondence: e-mail: patricia.baetens@az.vub.ac.be

Abstract

Donor insemination may provide an answer to transsexuals with female partners who have a wish for a child. Although the follow-up on children born in the context of these families is non-existent and the follow-up on transsexuals after sex reassignment surgery (SRS) is limited, fertility centres might consider accepting the requests of transsexuals with a female partner. Between 1997 and 2001, nine couples presented themselves at the Centre for Reproductive Medicine of the Dutch-speaking Brussels Free University, of whom five couples were accepted. Nevertheless, some caution is called for because transsexualism is socially not accepted. Moreover, transsexualism is still considered to be psychiatric condition. The following recommendations should be taken in consideration. Treatment should be limited to female-to-male transsexuals with a female partner. A multidisciplinary team of specialists should carry out the diagnosis for gender identity. Developmental problems of the gender-disordered child might interfere with socio-economic, psychological and emotional stability in adulthood. The period of sex reassignment should be nearly completed.

Keywords: counselling, donor insemination, female-to-male transsexuals with a female partner, gender identity disorder

Introduction

Donor insemination (DI) may provide an answer for transsexuals with female partners who wish to have a child. The first two couples requesting DI came to the Centre for Reproductive Medicine of the Dutch-speaking Free University of Brussels in 1997. One couple was a 24-year-old female-to-male (female-to-male) transsexual with a 50-year-old female partner, and in this case, treatment was not even discussed because of the age limit imposed on women wishing to become pregnant. The partner of the other couple presented himself as a transsexual, but was in fact a case of congenital adrenal hyperplasia (CAH). The couple was living in marginal and isolated circumstances and therefore not accepted for treatment.

In 2000, a new couple presented themselves at the centre. At this time, this alternative request was carefully discussed by the Bioethics Committee of the Centre for Reproductive Medicine and it was decided to extend treatment with donor semen to female-to-male transsexuals with female partners. Nevertheless, the decision to comply with these types of

alternative requests implied careful and intensive psychological support of each request because the controversial nature of the requests could not be ignored. In 2000 and 2001, seven couples applied for treatment with donor semen. Five couples were accepted. Two couples were rejected because of unstable living conditions.

Diagnosis of gender identity disorders

The topic of transsexuality or gender identity disorders as referred to by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) requires some familiarity with basic terminology. Gender identity refers to a person's fundamental sense of belonging to one sex. Gender role refers to behaviours, attitudes and personality traits that a society designates as masculine or feminine and that is appropriate to, or typical of the male or female social role (Zucker and Bradley, 1995). Sexual orientation is a person's sexual attraction towards another individual (Golombok and Fivush, 1994).

Transsexuals belong genetically to one sex, but their gender identity is not consistent with the biological sex. Transsexual men and women adopt the gender role and clothing of the desired opposite sex. Nevertheless, wearing clothes of the opposite sex does not induce sexual arousal. Female-to-male transsexuals are nearly all attracted to female partners, whereas in male-to-female transsexuals sexual attraction can be towards males, towards females, towards both or towards neither (Bower, 2001). Transsexuals will consider sex reassignment surgery (SRS) as the only effective treatment for their gender identity disorder.

Gender identity disorders can only be diagnosed by subjective criteria. The gender identity disordered patient presents himself to the physician as a physically, endocrinologically and genetically normal individual. Research shows that the degree to which gender-related traits distinguish transsexuals from non-transsexuals strongly correlated to the degree to which the same traits distinguished non-transsexual men from non-transsexual women. Nevertheless, male-to-female transsexuals were quite similar to gay men on all gender-related traits except self-ascribed femininity, whereas female-to-male transsexuals were considerably more masculine than lesbian women (Lippa, 2001). Psychological tests might help to diagnose transsexuals, but the measures do not differentiate enough with homosexuals and non-conformity to stereotypical sex role behaviour. Frequently, the diagnosis emerges during a clinical interview, often before SRS is considered by the patient (Bower, 2001).

The DSM-IV diagnostic criteria for gender identity disorder, adolescents and adult criteria, are: (i) a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being of the other sex); (ii) persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex; (iii) the disturbance is not concurrent with a physical intersex condition; (iv) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 1994).

According to Bower (2001), analysis of the DSM-IV classification of gender identity disorder has shown the DSM-IV criteria to be adequate, although there are some shortcomings. DSM-IV criteria do not stress sufficiently that cross-gender identification starts prior to puberty.

The assessment of whether or not someone is transsexual is often performed as part of the preliminary work-up to SRS. Nevertheless, as the surgery is irreversible, it is of prime importance that the diagnosis is accurate. A careful assessment over 2 years of the candidates prior to SRS is recommended (Meningaud *et al.*, 2000), sometimes with the expectation of a period living as the other sex or a so-called 'real life test'. The international Gender Dysphoria Association of Care also requires evidence of stability in work or school and social functioning (Zucker and Bradley, 1995).

Differential diagnosis should be made with non-conformity to stereotypical sex role behaviour, transvestite fetishism, congenital intersex conditions and schizophrenia. Non-conformity to stereotypical sex role behaviour also refers to

children with a gender identity disorder, for whom homosexuality is the most common post-pubertal outcome (Zucker and Bradley, 1995). Follow-up research of children with gender identity disorders shows that only a very small minority of these children will seriously entertain the notion of sex reassignment in adolescence (Green *et al.* 1987; Zucker and Bradley 1995).

Furthermore, differential diagnosis should be made with schizophrenia. According to Bower (2001), schizophrenic patients presenting behind a mask of gender dysphoria are not uncommon. A persistent preoccupation with castration or penectomy without a desire to acquire the sexual characteristics of the other sex can constitute a clinical symptom occurring in schizophrenia, dysmorphophobia, phobic conditions or culture-bound reactive psychosis (Bower, 2001). Consequently, it could be argued that a multidisciplinary team of specialists should carry out the diagnosis for gender identity disorder in order to be sure that DI is requested by true transsexuals.

Gender role development in children and adolescents

Gender identity in children is thought to be established between 2 and 3 years of age and it tends to remain fixed throughout life. Correct self-labelling is viewed as an important motivational force in influencing subsequent gender role behaviour (Kohlberg, 1966).

From the first day, infants live in a highly gendered world. Parents have very different expectations about what a male or female baby is like and the behaviour of the child will be interpreted differently according to the child's sex. Children label themselves as male or female around the age of 2 years and associate particular behaviours and traits very shortly after this with one gender or another. Once gender constancy is reached, children will identify with their own sex and engage in activities to enhance their identification and membership of their own gender group (Kohlberg, 1966). Peers, more than adults, reinforce gender-typed toy choice or playing with same-gendered peers (Golombok and Fivush, 1994).

Distress therefore occurs in children with gender identity disorder when cross-gender behaviour interferes with the social and family network of the child. Given the ubiquity of gender as a social category, this must lead to problems in the social interactions of children with gender identity disorders and thus lead to general behavioural psychopathology. Data from the Child Behaviour Checklist (CBCL) show that boys and girls with gender identity disorders were in general more disturbed than their siblings. Gender identity disordered children are at risk for internalizing symptomatology such as depression, social withdrawal and anxiety and externalizing symptomatology such as hyperactive, delinquent and aggressive behaviour. Both boys and girls show lower social competence (Zucker and Bradley, 1995). Nevertheless, the female stereotype is more flexible than male stereotypes, and girls therefore have more freedom to deviate from the female stereotype. Girls can engage in cross-gender activities with little penalty, whereas boys are not able to cross-gender quite so easily (Golombok and Fivush, 1994).

Gender dysphoric adolescents are often lonely, feeling uncomfortable in same-sex peer relationships to which they feel erotic attraction, and feeling more comfortable with peers of the opposite sex with whom they share interests. Nevertheless, they tend also to feel distanced in these relationships because they do not want to divulge their sexual feelings. They regard a homosexual adaptation as unacceptable and do not define themselves as homosexual. Male adolescents may find their growth in stature, their facial hair and musculature very distressing. Female adolescents experience frustration in concealing breast development and a menstrual cycle. The majority of adolescent transsexuals have poor anxiety tolerance and this manifests itself in character pathology, substance abuse, depression and suicidal ideation (Zucker and Bradley, 1995).

Gender identity disorder should be considered as one of the most important intra-psychic problems starting early in life, with extensive consequences for the psychosocial, emotional and behavioural development of the children. Developmental problems might interfere with socio-economic, psychological and emotional stability in adulthood.

Follow-up of adult transsexuals

In 1997, the occurrence of transsexuals in Germany was estimated at 2.1 per 100,000 adults. In Singapore and the Netherlands prevalence rates were 1:10,000 men and 1:30,000 women (Cohen-Kettenis and Gooren, 1999, van Kesteren *et al.*, 1996). This sex ratio was confirmed in France (Cordier, 2002, personal communication), Sweden, England and Wales (Bower, 2001). Prevalence rates show that only a small number of the general population will be transsexuals (0.01% for men and 0.003% for women).

According to Zucker and Bradley (1995), male transsexuals consist of two subgroups. Firstly, early-presenting males (in their 20s) who have a history of childhood cross-gender identification and sexual attraction towards males. Secondly, later-presenting males (in their 30s and 40s) have often a history of transvestite fetishism and sexual attraction towards women. Adult females with gender dysphoria are comparable to early-presenting males and almost invariably experience same-sex attraction (towards female partners). An epidemiological and demographic study in the Netherlands shows that female-to-male transsexuals apply for reassignment between the ages of 20–25 years, whereas the majority of male-to-female transsexuals do so between the ages of 25 and 30 years (van Kesteren *et al.*, 1996). A follow-up of 233 transsexuals who applied for sex reassignment in Sweden showed that male-to-female transsexuals were older when applying for SRS and more often had a history of marriage and children than their female-to-male counterparts (Landen *et al.*, 1998a).

Individuals with gender dysphoria appear to be at high risk for psychiatric impairment, including character pathology, substance abuse, depression, suicide and trouble with the law. Cole *et al.* (1997) studied the co-morbidity between gender dysphoria and major psychopathology evaluating 435 gender dysphoric individuals who had undergone extensive evaluation and of whom two-thirds were undergoing hormone treatment. One-quarter had problems with substance abuse prior to

entering the treatment but less than 10% evidenced problems associated with mental illness, genital mutilation or suicide attempts (Cole *et al.*, 1997). Haraldsen and Dahl (2000) compared 65 transsexual patients after SRS and 35 transsexuals who applied for SRS with 98 patients with personality disorder and 1068 healthy controls. They found that transsexual patients showed relatively low level of self-rated psychopathology before and after treatment. The scores of transsexual patients on the Global Symptom Index and the Symptom Checklist 90 were within the normal range, slightly higher than the healthy control group, but significantly lower than patients with personality disorders (Haraldsen and Dahl, 2000). Nevertheless, research on a cohort of 218 transsexuals showed that 3.8% of the patients who had sex reassignment between 1972 and 1992 in Sweden regretted the measures taken. Risk factors that predicted regret were lack of support from the family and the patients belonging to the non-core groups of transsexuals (Landen *et al.*, 1998b).

Female-to-male transsexuals seem to be less at risk for psychiatric impairment (De Cuypere *et al.*, 1995; Zucker and Bradley, 1995; Cohen-Kettenis and Gooren, 1999). Female-to-male transsexuals appear to have more stable relationships and are socially better integrated (Flemming *et al.*, 1985; Kockott and Fahrner, 1988; Zucker and Bradley, 1995). Moreover female-to-male transsexuals appear to have slightly better economic outcome (Tsoi, 1992; Zucker and Bradley, 1995). They have a more convincing gender role behaviour and looks and they are less stigmatized in childhood (Cohen-Kettenis and Gooren, 1999). Although female-to-male transsexuals were less satisfied with the result of SRS, they adjusted well to the male gender role (Tsoi, 1993). Prostitution is only reported in studies of male-to-female transsexuals (Tsoi, 1992). The outcome after 5 years showed that the psychosocial functioning improved for 68% of the transsexuals ($n = 19$) with a better outcome for female-to-male transsexuals, especially concerning establishing and maintaining partnerships and improvement in socio-economic status. Nevertheless, three patients were unchanged and three patients had worsened after 5 years in several areas of social, psychological and psychiatric functioning (Bodlund and Kullgren, 1996). The number of cases of death and morbidity in 425 transsexual patients who had been treated showed that this number was five times the number expected due to increased number of suicides and death due to unknown cause in male-to-female transsexuals (Asscheman *et al.*, 1989).

Although long-term follow-up research of adult transsexuals is limited, it appears that female-to-male transsexuals show fewer psychological disturbances, less psychopathology, have more stable relationships with the female partner, are socially better integrated and have a better economic outcome, and it can therefore be argued that treatment should be limited initially to female-to-male transsexuals with a female partner.

Transsexual parents

Only one empirical study concerning transsexual parenthood has been carried out. In research concerning 37 children raised by homosexual and transsexual parents, 16 children were raised by transsexual parents in seven families (Green, 1978). Furthermore, one case study is reported on a transsexual father (Sales, 1995).

According to Brothers and Ford (2000), individuals with gender identity disorder exhibit the full range of social class, intellectual competence, sexual orientations and mental stability or illness seen in the general population. The couples should be assessed using the same criteria as heterosexual couples, with the overall constraint that the welfare of future children must be the paramount consideration. Jones (2000) reports that no studies are available providing information on the outlook for a child reared by a transsexual parent. The lack of follow-up research on children of transsexual parents should call for caution.

Female-to-male transsexuals and the wish for a child

Five couples were accepted for DI in our centre. All couples were female-to-male transsexuals with a female heterosexual partner. The mean age of the transsexual partner and the female partners was 31 years. The mean duration of the relationship was nearly 5 years and the couples had lived together for 3.8 years on average. Four couples were French, although one female partner was of Russian origin. The other couple was Turkish, although the couple was living in Germany.

Multi-disciplinary teams of specialists prior to the SRS carefully screened all transsexuals except one. All five had had hysterectomy and breast reduction. Two had phalloplasty but surgery for one transsexual failed because of infections. He was scheduled for a new trial. One decided not to continue the phalloplasty because the sexual functionality was considered poor and the risks of infections too high. One was still uncertain about phalloplasty and one was scheduled for phalloplasty. Three transsexuals started SRS during their relationship. One transsexual changed the gender identity on his passport. The other four had started a juridical procedure to change their official identity.

For one transsexual, the current relationship was the first one. The previous relationships of the other female-to-male transsexuals were with heterosexual woman. None had had a relationship with a man or a lesbian woman.

All female partners were informed from the start of the relationship about the transsexuality of their partner. All previous relationships of the women were with men. One female partner had three children. Two families of female partners were not informed about the transsexuality of their daughter's partner. Two families of the female partner accepted the transsexual partner and one family rejected the partner.

All female-to-male transsexuals were early onset transsexuals. During childhood they played with boys and boys' toys, they dressed like boys and chose studies and professions that are generally considered to be more 'male'. All transsexuals were socially rather isolated in childhood and adolescence, not knowing how to cope with peers. Two transsexuals broke up with their past life before SRS and in their new life no one knew that they had been a woman. These two had also started their own business so as not to have any problems in professional relationships. The other three transsexuals

continued to see people they had known during childhood and adolescence and had some childhood friends. These couples had better social integration. One was accepted in his professional environment, one was working in a professional environment where his gender identity was not discussed and one did not have a job.

For one transsexual, cross-gender behaviour induced severe conflicts with the parents, who tried to prevent this behaviour. All transsexuals could label themselves as a transsexual in adolescence, but started SRS in adulthood. All transsexuals informed their parents when adolescent, but their parents did not believe them. They informed their parents again just before the start of the treatment. Three transsexuals were accepted by their families. Two transsexuals had little contact with their families.

All couples decided to apply for DI once the transition period for gender reassignment was medically coming to an end. The period before and during the actual sex reassignment was considered to be a stressful period, emotionally and socially, for the female-to-male transsexual and his partner. Moreover, all couples decided to apply only when the relationship was proven to be stable and there was also financial stability. Four couples decided to tell their child about donor insemination and transsexuality, even though the family of one of the female partners was not informed about the transsexuality of the partner and could not be informed at any time for socio-cultural reasons. One couple decided not to tell the child. Since his new social contacts were not aware of the fact that he had been a woman, contact with a small number of family members of the transsexual partner was limited. Similarly, since the family of the female partner did not know about the transsexuality, they considered the risk that the child would find out through others limited. All female-to-male transsexuals defined their parental role as the role of a father.

One couple did not start DI because they emigrated, and they intended to look for a fertility centre in Canada willing to help them. Four couples started treatment. One couple had two inseminations and one had three inseminations. No information is available regarding the outcome of the last insemination of both couples. One woman was pregnant after the second insemination, but had a miscarriage. The couple came back for a third treatment but no information is available on the outcome of this treatment. One woman, who had three children from a previous relationship, gave birth to a girl in March 2001. Because of the limited number of children born so far (one girl of nearly 2 years, who is developing well), follow-up research of the children seems premature at this moment. Nevertheless, follow-up research of the children is essential in the future to be sure that the welfare of such children is not at risk.

Conclusion

Although the follow-up on children born to transsexual partners with a female partner is non-existent and the follow-up of adult transsexuals after SRS is limited, fertility centres might consider accepting the request of some couples. Nevertheless, some caution is called for because transsexualism is socially not accepted and is still considered

to be a psychiatric condition. Transsexualism might therefore have some negative consequences for the transsexual, the partner and the future child.

Fertility centres are, of course, limited in the help they can offer to transsexuals. DI may provide an answer for female-to-male transsexuals with a female partner or male-to-female transsexuals with a female partner. Female-to-male transsexuals show fewer psychological disturbances, less psychopathology, have more stable relationships with female partners, are socially better integrated and have a better economic outcome. It might be recommended, initially, to limit treatment to female-to-male transsexuals with female partners.

Moreover, it should be recommended that a multi-disciplinary team of specialists should carry out the diagnosis of gender identity disorder. Discomfort about one's biological sex can interfere with other psychiatric conditions and congenital intersex conditions, and careful assessment therefore seems a necessity, because not all gender dysphoric patients are true transsexuals. The International Gender Dysphoria Association of Care also requires evidence of stability in work and social functioning during a 'real life test' prior to SRS, two criteria that might be considered important if one wishes to procreate.

Gender identity disorders might be considered as one of the most important intra-psycho problems, starting in early childhood and with extensive consequences for the psychosocial, emotional and behavioural development of the gender identity disordered child. Developmental problems during childhood might interfere with socio-economic, psychological and emotional stability in adulthood and it should be recommended therefore to assess childhood experiences of the transsexual adult with a wish for a child.

Moreover, the transition period for gender reassignment is considered a very stressful period. It is recommended, therefore, that this period of sex reassignment should be nearly completed, providing the necessary stable life situation for the future child.

In 1981, the centre was the first to provide DI to lesbian couples and this option did not reflect a general attitude towards these requests. Nevertheless, research on children raised by lesbian mothers because of adjudication in child custody disputes existed already and supported the decision to accept these alternative requests. Contrary to lesbian parenthood, research concerning transsexual parenthood is limited to one empirical study. Some questions therefore remain unanswered, such as should the child be informed about the transsexuality of the father? For lesbian couples, for instance, it is recommended to tell the child about the homosexual nature of the relationship, the conception with donor spermatozoa and the anonymity of the donor at an early age (Baetens *et al.*, 2002). Nevertheless, the coming-out of transsexuals seems to be more limited and some transsexuals even broke up with their past life to avoid their current social contacts knowing about their past as a women. Young children have no notion of privacy and in these cases, there is a problem regarding when the child should be told about the transsexuality of his father. If the child is only told about his

conception what should be mentioned as a reason for the use of donor spermatozoa?

An increasing number of homosexuals are coming out of the closet and homosexuality has been brought to the attention of society. Lesbian couples can be reasonably confident that society will accept them. This is not true for transsexuals, who experience more discrimination than do lesbian couples. The risk of stigmatizing might be more important for children of transsexual fathers and the child therefore might be more at risk of social isolation.

Furthermore, what will be the consequences for the sexual identity of the adolescent child of a transsexual father? Transsexual parenthood raises a lot of questions about the consequences for the children. Follow-up research of the children raised in households with a transsexual father is therefore essential. Until then, the lack of information on the consequences for the child to be raised by a transsexual parent will reduce the debate to balancing the reproductive rights of transsexuals against the welfare of the child.

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